Pharmacists as dispensers and formation of the PPA

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In our series on the history of prescribing policy, Dr Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he explains how pharmacists became dispensers and how the Joint Pricing Committee was replaced by the PPA.

KEY EVENTS

- 1852 Pharmacy Act passed – pharmacists split from other medical practitioners
- 1858 Medical Act passed – pharmacists were not eligible to become registered medical practitioners
- 1913 National Insurance Scheme introduced – separated the drugs from the doctors, leaving pharmacists as dispensers
- 1974 PPA introduced – replaced the Joint Pricing Committee with remit of reimbursement and data creation

In order to establish a publicly-funded pharmaceutical service, free at the point of delivery, the architects of the NHS had to secure the involvement of the country's self-employed family doctors and pharmacists.[1,2] Previously, these professionals worked independently providing services both privately and to insured patients on local panel lists. With the inception of the health service, general practitioners were offered a new list-based remuneration structure while pharmacists were paid for the number of items that they dispensed.

For both groups, the introduction of the NHS greatly diminished their opportunities for private practice and their main incomes were now derived mainly from the state. As 'independent contractor', however, both doctors and pharmacists were given many of the freedoms that they had previously enjoyed as private practitioners. As a result, successive governments had little control over their professional activities and the type and volume of drugs supplied.

The pharmacist as dispenser

Although the role of general practitioner as prescriber and the pharmacist as dispenser now seems natural, this separation of professional activities was due more to accident than design.[3]

According to Sidney Holloway, the official historian of the Royal Pharmaceutical Society, during the 1800s pharmacists were seen as members of the medical profession alongside apothecaries, surgeons and midwives.[2] However, the 1852 Pharmacy Act artificially split them from other medical practitioners by defining registered pharmaceutical chemists and pharmacists as practitioners not examined in medicine, surgery or midwifery.

This artificial split was further consolidated by the 1858 Medical Act, which Holloway believed created an institutional barrier that 'does not represent a natural process of specialisation of function'.

The National Insurance Scheme

While successive acts of parliament separated the profession of pharmacy from mainstream medicine, the introduction of the National Insurance Scheme (NIS) in 1913 further institutionalised this artificial split. Before the implementation of the panel system, most doctors personally compounded and supplied the medicines

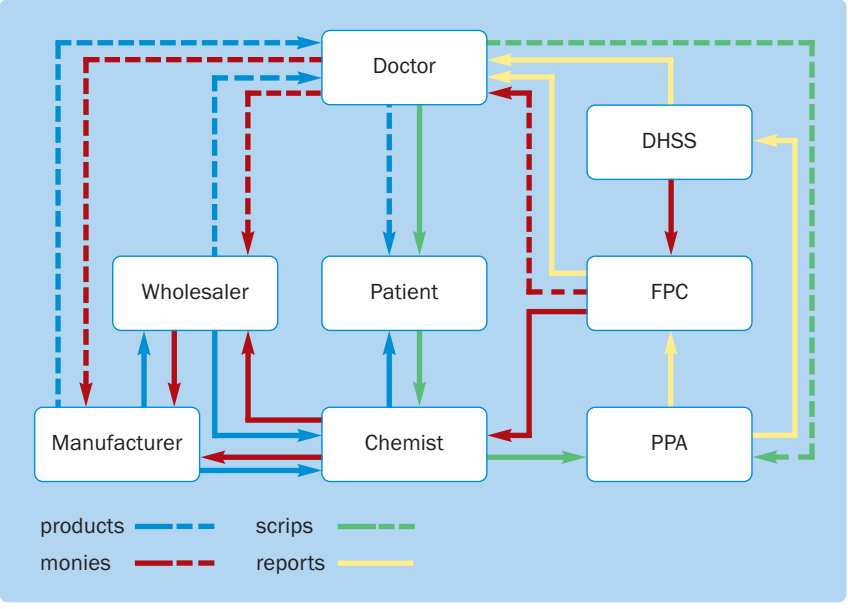

Figure 1. The system for prescribing, dispensing, reporting and payment, 1977 (broken lines for dispensing doctors); after reference 5

that they sold to patients. A drug recommended by a general practitioner was rarely dispensed by a local pharmacist because this would have greatly reduced family doctor incomes.

When reviewing the arrangements for the NIS, the Chancellor of the Exchequer, Lloyd George, feared that some doctors would try to increase their prescribing in order to raise their incomes.[4] This was possible because the panel, not individual patients, paid for the medicines supplied. In response he told Parliament, 'The first thing which I think should be done is to separate the drugs from the doctors, because a patient, so long as he gets something discoloured and really nasty, is perfectly convinced that it must be a very good medicine'.

He added that the business of the doctor 'should be confined to prescribing. It should be for the chemist to dispense. At any rate, there should be a compulsory separation of the two.' However, in isolated geographical areas there should be no separation because 'you cannot expect a man to start a chemist's shop in a Highland glen'.

He therefore proposed to make provision that, if there is no chemist available, the doctor should be allowed to continue the current arrangement, but wherever there is a chemist available patients should receive a prescription and pharmacists should dispense.

However, this proposal left unresolved the issue of whether pharmacists should be allowed to move into areas without existing pharmacies where doctors have a sizeable dispensing business. Unfortunately for the architects of the NHS, this issue was left unresolved under NIS regulations and the underlying tension of whether pharmacists should open in rural areas was carried unaddressed into the new arrangements.

Formation of the PPA

Although the compulsory separation of prescribing and dispensing addressed the problem of doctor profiteering, during the early 1970s the Joint Pricing Committee was still experiencing problems reimbursing the cost of medicines and providing the Department of Health and Social Security (DHSS) with timely prescribing reports.[5] In consequence, the committee was replaced by the Prescription Pricing Authority (PPA) as part of the 1974 NHS reorganisation.

The PPA served two functions within the prescribing and dispensing systems operated by the NHS (see Figure 1). Firstly, the authority processed the scrips issued by community pharmacists and dispensing doctors and reported to their local family practitioner committees (FPCs) on the reimbursement that they should receive. (FPCs replaced Executive Councils as part of the 1974 reorganisation.)

Secondly, the authority was charged with providing the DHSS and all FPCs with reports on the prescribing behaviour of individual doctors. In turn, FPCs could use these data as part of their procedures for investigating excessive prescribing.

As the diagram shows, during the 1970s the arrangements for supplying and reimbursing pharmaceuticals were complex, especially because of the different arrangements that had been made for dispensing doctors.

Moreover, the processes used for calculating payments and creating prescribing data were manual because computing power and processes had yet to be developed for the PPA. NHS systems for reimbursing and monitoring medicines would therefore remain slow and cumbersome until the revolution in computing that occurred within the pricing authority towards the end of the 1980s.

Indeed, the introduction of Prescribing Analysis and CosT (PACT) data in August 1988 was a tipping point in the history of NHS prescribing policy

References

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The next article in the series will look at the recommendations made by the Tricker and Clothier reports.